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Michael F. Easley, Governor

Dempsey Benton, Secretary

March 26, 2008

MEMORANDUM

TO: Joint Legislative Oversight Committee on Mental Health Developmental Disabilities and Substance Abuse Services

FROM: Dempsey Benton

SUBJECT: Update

I. State Psychiatric Hospitals

A. Central Regional Hospital – Dix Closing

Based on the review of the final construction work, the time needed to complete the IT (Information Technology) system after full acceptance of the facility and getting our final staffing plan in place, the transition to the new hospital will be delayed until July 1, 2008. A transition plan has been developed and the actual physical transition would begin the first week in June 2008.

The addition of the 60-bed Dix acute unit required a shift in staffing plans from the original closing plan and time is required to allow fair consideration in hiring decisions for the more than 150 positions to staff this unit. This will require us to fill the vacated staff slots at Central Regional Hospital due to this change.

Also contributing to this decision is getting federal approval for the Dix Unit – a 60-bed acute unit to be located on the Dorothea Dix campus – as well as getting the final agreement in place with Wake County for operating this unit. It is expected that 24 beds would be operational at the time of transition. Minor renovations are needed to open the full 60 bed unit, and it should take only several weeks to prepare the area. As previously reported to the committee, the FY 08-09 budget for the 60 bed Dix unit is approximately $9.6 million with Wake County's cost being $4.7 million and the state cost being approximately $4.9 million.

Final inspection work continues on the hospital. Modifications continue to be made as needed including:

- Modifying handicapped bathroom grab bars to eliminate the potential hanging risks.
- Adding impact resistant glass panels to the openings in three stairwells.
- Enclosing any exposed roof access ladders.

The change order cost for these adjustments is $23,600.
At opening, the Central Regional Hospital should meet all guidelines set forth by the American Institute of Architects (AIA) for psychiatric facilities. AIA Guidelines are also used by the Joint Commission on Accreditation of Health Care Organizations. The new hospital will also meet the requirements of N.C. Department of Insurance, State Building Code as well as the N.C. Division of Health Services Regulation's requirements for the Centers for Medicare and Medicaid Services (CMS) and North Carolina licensure regulations.

In January, a group of hospital and behavioral health professionals from outside the department were asked to review the new facility. This Group has met several times since their appointment and the committee has made a site visit to the facility. Their main concern is the size and configuration of the restraint rooms. This is an issue of clinical preference and discussions among committee members and state staff are continuing to resolve their concerns.

B. Future Construction

Design is underway for the new Cherry Hospital in Goldsboro. An individual has been hired to be constructions liaison between the design team and the facility management. The liaison will attend all design meetings to represent the views of Cherry Hospital management. The design is scheduled to be completed by December 2008 and construction will begin in February 2009. The number of beds at Cherry will increase from the current 274 to 304 at the new facility. Adult admission bed capacity will increase from 90 to 120. Completion is projected to be February 2011.

The new Broughton Hospital facility is projected to have 383 beds (+68). Pursuant to legislation for capital financing, initial design would commence in the summer, 2008. Estimated completion date is February 2012.

C. Hospital Operations

By June 2008, the installation of cameras in all restraint rooms at Cherry Hospital and Broughton Hospital will be complete. Central Regional Hospital will have cameras installed by opening date.

Dr. Jeffery Geller has been retained as an external expert to provide ongoing consultation and training in clinical operations. Dr. Geller starts his work during the next quarter (April-June 2008). He is a nationally recognized expert in psychiatric hospital management.

A Management and Operations Work Group was appointed in January 2008 to review hospital practices, safety and staffing. They have been meeting since mid-January. The members include hospital and behavioral health professionals from outside of the department and well as state hospital directors. The workgroup is addressing standardization of policies, protocols for restraints, and staffing to patient ratios. They are helping develop system wide DHHS policies that will supersede local hospital policies and will provide uniform approaches to incidents and investigations.

One of the workgroup's interim assessments is that the staff to patient ratios need to be improved. This is likely to involve consideration of additional positions especially in Registered Nurses (RN) in the 08-09 Budget.

Staff retention is also a challenge. For example: In 2006-2007, RN turnover was 22.5% at Broughton, 31.4% at Dix, 14% at Umstead, and 10.6% at Cherry.

Effective March 17, 2008, by Direction of the Secretary all deaths at state operated facilities within DHHS will be reported to the State Medical Examiner's Office. Proposed legislation has been developed to address this requirement. Please see the attachment. As indicated, there is a fiscal impact of $158,351 in FY 08-09.

Broughton Hospital has submitted the application to be recertified as a Medicaid and Medicare provider. The CMS inspections are underway this week.

The Hospital Directors are making adjustments which address improving quality of patient care.

At Broughton, there has been a 55% reduction in total seclusion and restraint hours in the period January 1 through March 9, 2008 as compared to the same time in 2007.

At Cherry, in 2007 restraint usage decreased by 35% from 2006. Recruiting and retaining key hospital staff is likely to warrant a workforce development strategy which could include recruitment incentives similar to those being utilized to attract physicians to rural areas of the state.

A review of the overall department management of State Hospitals is being undertaken. In addition to the retention of Dr. Geller as noted herein, there is the need for an internal inspection team which will review hospital operations with a focus on functions similar to those utilized by CMS inspections.

For the hospitals, greater capacity is needed to train nurses on the requisite practices and protocols. The level of turnover makes this enhanced management function a clear necessity.

These management issues would need to be addressed in the FY 08-09 budget.

II. Crisis Services and Community Capacity

Provision of MH/DD/SA crisis services across the state is at an uneven, inconsistent level. Some communities appear to have an adequate 24/7 service and some appear to have an adequate 8 to 5 service with limited after hours capacity. For some areas, it is difficult to ascertain if a crisis service is available at all.

Perhaps the data which is indicative of the challenge is that last year 121,000 Medicaid eligible persons went to hospital emergency rooms with behavioral health problems. Recent reports indicate the total number going to ERs with Mental Health or Substance Abuse could approach 400,000 per year.

A more comprehensive emergency or crisis service approach is needed, with a statewide focus. Based on the effort of the Crisis Services Workgroup, a more robust mobile crisis service could provide a more responsive service than now exists. The department is developing information on the concept for consideration in the FY 08-09 budget process.

Community Impatient capacity is a critical part of the MH/DD/SA system. It is especially important in addressing crisis services. Since 2002, the community hospital involuntary commitment inpatient capacity has decreased by approximately 15%.

Effective Crisis Services and adequate Community Inpatient beds are a fundamental part of the state's overall health care system, not just for behavioral health. Adjusting use of Emergency Rooms helps their overall capacity. Law Enforcement services can be moderated with the availability of crisis services and community impatient beds.

The Crisis Services Work Group is recommending that the state invest in securing community capacity for state funded patients and a plan is being developed to address this need in the 2008-09 budget.

III. Provider System

A critical part of the Mental Health system is the delivery of services by private providers.

In a number of services, especially Community Support, the qualifications for eligible providers were not adequately established. Some adjustments have been made to establish a minimum level of work in the Community Support service by certain skilled individuals.

It is necessary to pursue more specific standards for providers. The State Plan approved by CMS includes the requirement that providers received national accreditation within 3 years from the time they begin participating in the N.C. Medicaid system. The department is developing a plan that relies on the national accreditation framework but requires specific performance benchmarks in the year leading up to accreditation. DHHS has indicated that national accreditation is a provider qualification requirement. However, it appears that many providers may not be taking the requisite steps to meet the 3 year deadline. The state should consider legislation tightening the standards and deadlines. The department is preparing proposed legislation for consideration. The department is also looking at adjusting the 3 year period to 2 years as well.

This approach is being considered in lieu of developing a separate Comprehensive Provider definition as previously noted to LOC.

IV. System Management

As the committee knows, the department is undertaking a review of the regional structure (LME) for managing the delivery of services and the state's oversight and direction of the LMEs. This work is underway but not finished. The department is in discussion with a consortium of three LMEs (Smokey, Guilford, and Mecklenburg) on the establishment of a single administrative service organization to provide more efficient approaches to certain management functions.

The handling of consumer and provider appeals is an issue discussed with the LOC at the February meeting. The current process allows providers who have been terminated to remain in operation, continue to deliver services, and receive payments while they appeal the department's decision.

Another issue for consumers is the timeline factor of providing a decision on the appeal within 90 days. The current system is not meeting this goal.

Attached are a report and a proposal to change the appeals process for consumers and providers. As noted, this change would be similar to the Division of Social Services appeals process established by the General Assembly.

In the management area, another adjustment being considered is the establishment of a basic psychiatric services in each region or LME. This does exist in some areas, but not in others. This would involve funding in the 08-09 budget. The availability of such services in each region would assist emergency services response systems, provide additional capacity for transitioning patients from the state hospitals back to the communities and create a "home base" for psychiatrists which would aid in recruitment for difficult to serve areas of the state.

This is a recommendation of the Crisis Services Workgroup. Implementation would involve retention of psychiatrists, equipment to facilitate telepsychiatry services, and social worker staff to be part of this strategy. The department is developing a FY 08-09 budget proposal for consideration.

G.S. 130a-383(a) is amended to read as follows:

130A-383. Medical examiner jurisdiction.

(a) Upon the death of any person resulting from violence, poisoning, accident, suicide or homicide; occurring suddenly when the deceased had been in apparent good health or when unattended by a physician; occurring in a jail, prison, correctional institution, state facilities operated in accordance with G.S. 122C Article 4, Part 5 or in police custody; occurring pursuant to Article 19 of Chapter 15 of the General Statutes; or occurring under any suspicious, unusual or unnatural circumstance, the medical examiner of the county in which the body of the deceased is found shall be notified by a physician in attendance, hospital employee, law-enforcement officer, funeral home employee, emergency medical technician, relative or by any other person having suspicion of such a death. No person shall disturb the body at the scene of such a death until authorized by the medical examiner unless in the unavailability of the medical examiner it is determined by the appropriate law enforcement agency that the presence of the body at the scene would risk the integrity of the body or provide a hazard to the safety of others. For the limited purposes of this Part, expression of opinion that death has occurred may be made by a nurse, an emergency medical technician or any other competent person in the absence of a physician.

Amend G. S. 122C-31 by adding a new section

§ 122C-31. Report required upon death of client.

(a) A facility shall notify the Secretary immediately upon the death of any client of the facility that occurs within seven days of physical restraint or seclusion of the client, and shall notify the Secretary within three days of the death of any client of the facility resulting from violence, accident, suicide, or homicide. The Secretary may assess a civil penalty of not less than five hundred dollars ($500.00) and not more than one thousand dollars ($1,000) against a facility that fails to notify the Secretary of a death and the circumstances surrounding the death known to the facility. Chapter 150B of the General Statutes governs the assessment of a penalty under this section. A civil penalty owed under this section may be recovered in a civil action brought by the Secretary or the Attorney General. The clear proceeds of the penalty shall be remitted to the State Treasurer for deposit in accordance with State law.

(b) Upon receipt of notification from a facility in accordance with subsection (a) of this section, the Secretary shall notify the State protection and advocacy agency designated under the Developmental Disabilities Assistance and Bill of Rights Act 2000, P.L. 106-402, that a person with a disability has died. The Secretary shall provide the agency access to the information about each death reported pursuant to subsection (a) of this section, including information resulting from any investigation of the death by the Department and from reports received from the Chief Medical Examiner pursuant to G.S. 130A-385. The agency shall use the information in accordance with its powers and duties under applicable State and federal law and regulations.

(c) If the death of a client of a facility occurs within seven days of the use of physical restraint or seclusion, then the Secretary shall initiate immediately an investigation of the death.

(d) An inpatient psychiatric unit of a hospital licensed under Chapter 131E of the General Statutes shall comply with this section.

(e) Nothing in this section abrogates State or federal law or requirements pertaining to the confidentiality, privilege, or other prohibition against disclosure of information provided to the Secretary or the agency. In carrying out the requirements of this section, the Secretary and the agency shall adhere to State and federal requirements of confidentiality, privilege, and other prohibitions against disclosure and release applicable to the information received under this section. A facility or provider that makes available confidential information in accordance with this section and with State and federal law is not liable for the release of the information.

(f) The Secretary shall establish a standard reporting format for reporting deaths pursuant to this section and shall provide to facilities subject to this section a form for the facility's use in complying with this section.

(g) In addition to the reporting requirements specified in (a) – (e) of this section and pursuant to G.S. 130A-383, state facilities shall report the death of any client of the facility, regardless of the manner of death, to the medical examiner of the county in which the body of the deceased in found.

Fiscal Note for the Division of Public Health/Office of Chief Examiner Assuming Responsibility
Investigating Deaths at State Mental Health Institutions
March 19, 2008

The proposed change is intended to require that every death occurring in a state facility operated in accordance with G.S. 122C Article 4, Part 5 be reported to and certified by the North Carolina Medical Examiner (ME) System. Currently such deaths, between 80 to 100 yearly, are only certified by the Medical Examiner system if they meet other statutory criteria, namely that they are unexplained, suspicious or the result of some injury, i.e., external causes. If a death in an institution appears to fall under Medical Examiner jurisdiction, any individual having knowledge of that death must report it to a county medical examiner. If the medical examiner deems that the criteria are met, jurisdiction is assumed and the death is investigated and certified. In those instances where the circumstances of the death are judged to require an autopsy, an autopsy is performed. With this proposed statutory change, the reporting would no longer be discretionary but required and every death would be certified by the medical examiner system.

This situation would be roughly parallel to that which applies to deaths in jail, prison or law enforcement custody. Since the inception of the medical examiner system, all such deaths have been required to be certified by the medical examiner system. While initially every such investigation also included an autopsy, our current practice is to perform autopsies in all custody deaths related to injury and those occurring unexpectedly, but not in instances where the inmate's death was expected. The latter category encompasses those patients with known terminal conditions whose death medically is clearly the consequence of that condition. It would be the Medical Examiner System position that deaths in institutions operated by DHHS would be handled in a similar fashion.

Thus, following the implementation of the proposed legislation, when a death occurs in a covered institution, the staff of that institution would contact the appropriate medical examiner to report the death. The medical examiner would initiate an inquiry and investigation into the cause and manner of death. In those instances when it was deemed appropriate, an autopsy examination would be performed by the medical examiner system. In making the determination in regard to an autopsy, the medical examiner would apply guidelines promulgated by the Office of the Chief Medical Examiner (OCME). Ultimately, all institutional deaths would be certified by the Medical Examiner System.

The proposed legislative change will directly impact operations at the OCME. Death investigation, regardless of whether an autopsy is required, will involve extensive review of the decedent's medical records, investigation into the circumstances leading up to the death, and case follow up with local MEs and other DHHS Divisions. The OCME does not have sufficient staff for the increased investigatory activities and these investigative activities will be crucial in determining cause of death and whether an autopsy is called for. Thus, the OCME proposes adding one Public Health Nurse Consultant positions to manage the expected workload. In addition, most if not all of the required autopsies would be performed at the OCME.

It is anticipated that approximately 100 deaths per year will occur and 60 will be autopsied. As the industry standard for Autopsies is approximately 250, the anticipated number does not warrant a full time Forensic Pathologist. Thus, we propose funding for Forensic Pathologists with whom

we may contract. Indicated below is a five year projection of costs. The projections are straight line as it is not possible to predict number of deaths in a year.

Account Title	SFY 2008-09	SFY 2009-10	SFY 2010-11	SFY 2011-12	SFY 2012-13
Nurse Salary	$66,001	$66,001	$66,001	$66,001	$66,001
Nurse Social Security	$5,050	$5,050	$5,050	$5,050	$5,050
Nurse Retirement	$5,168	$5,168	$5,168	$5,168	$5,168
Nurse Med Ins	$4,157	$4,157	$4,157	$4,157	$4,157
Sub-Total	$80,376	$80,376	$80,376	$80,376	$80,376
Position Support Costs, i.e., travel, office supplies	$5,650	$5,650	$5,650	$5,650	$5,650
Supplies Needed for Autopsies	$4,500	$4,500	$4,500	$4,500	$4,500
Sub-Total Operating	$10,150	$10,150	$10,150	$10,150	$10,150
Contract Funding for ME's and Pathologists to Conduct Investigations and Perform Autopsies	$46,700	$46,700	$46,700	$46,700	$46,700
Dead Body Transportation to OCME for Autopsies to be Performed ($300 per autopsy)	$18,000	$18,000	$18,000	$18,000	$18,000
Total Recurring Costs	$155,226	$155,226	$155,226	$155,226	$155,226
Furniture-Office	$1,500	0	0	0	0
PC/Printer	$1,600	0	0	0	0
Grand Total	**$158,326**	**$155,226**	**$155,226**	**$155,226**	**$155,226**

APPEALS PROPOSAL FOR LEGISLATIVE OVERSIGHT COMMITTEE
March 26, 2008

I. BACKGROUND

As the Department informed this Committee during the last meeting, Medicaid appeals are overwhelming the current system. You were provided with some numbers that showed the number of pending informal appeals (appeals to the Division of Medical Assistance asking them to reconsider the decision). The numbers you were given were comprised of both provider appeals and recipient appeals. On February 22, the total number of informal cases pending was 6,621. As of Friday, 3/14, there were 6,812 informal cases pending (5,936 of which are related to community support services).

II. CURRENT APPEALS PROCESS

A. Informal Appeals

As Emery Milliken explained at the last LOC meeting, if a Medicaid recipient or provider disagrees with Medicaid's decision, they may ask the Division to reconsider that decision. Those reconsiderations by the agency are referred to as "informal appeals". Currently, there are five hearing officers plus a chief hearing officer who handle those informal hearings. (This number does not include the temporary positions and recent reassignments to handle the community support workload.)

A recipient/provider may ask for an "in-person hearing", a "paper review" or a "telephone hearing". The informal appeal is just that – informal. There is no sworn testimony allowed and there is no cross examination of witnesses. These "hearings" are more an opportunity for each side to explain its position to the hearing officer and to ask questions of each other.

If a recipient hearing is an "in-person hearing", the hearing typically lasts approximately one hour and involves the recipient, whoever the recipient wishes to have present or phone in, the hearing officer and a representative from the DMA or from the Contractor who made the decision being appealed. (For instance, if it's a Value Options ("VO") decision being appealed, VO will have the involved clinician available in person or by phone to answer questions the recipient or Hearing Officer may have and to explain the VO decision.) Once the informal appeal hearing is held, the recipient receives a written decision within about two weeks.

That informal appeal decision may reverse, affirm, or modify the Division's decision. If the decision is still a denial to the recipient, the notice will advise the recipient of his/her appeal rights to the Office of Administrative Hearings ("OAH"). Similarly, with a provider, if the decision is not in its favor, the written decision advises the provider it may appeal to OAH.

When a provider requests an informal appeal, the hearing typically takes two hours and often times longer depending on the issues. There are normally more witnesses and if documentation is an issue, the hearing can be more extensive. However, many providers skip the informal appeal and go straight to OAH.

B. Formal Appeals

Federal law requires that the State must grant aggrieved applicants and recipients an evidentiary hearing, often referred to as a fair hearing. 42CFR 431.200. In general terms, a fair hearing requires sworn testimony and the right to cross-examine witnesses. 42CFR 431.205. Currently the fair hearing occurs at the Office of Administrative Hearings. The informal appeal process is a reconsideration of the agency decision, testimony is not taken under oath, and there is no right to cross-examine witnesses.

For providers it should be noted that federal law does not require the same kind of fair hearing process as for recipients. Moreover, there is substantial case law holding that providers do not have a property right to be a Medicaid provider, i.e., it's a privilege and not a right to be a Medicaid provider. However, Medicaid providers should be accorded due process. In most provider cases, the issue is one of contract, i.e., whether or not the provider has breached the provider agreement. Currently, North Carolina Medicaid accords providers the same informal appeal and OAH process as that of recipients. There is no federal requirement that it be the same.

The recipient or provider has 60 days to appeal a Medicaid decision to the Office of Administrative Hearings. To appeal a decision to the Office of Administrative Hearings, a recipient/provider ("petitioner") must file a contested case petition at OAH and serve it on the agency.

After OAH receives the petition, OAH serves several pleadings on the petitioner and the agency (or the agency's attorney – the Attorney General's Office). These pleadings include: the Order for Prehearing Statement, the Scheduling Order and the Notice of Contested Case and Assignment. The Order for Prehearing Statement requires the petitioner and respondent to file a pleading with OAH that provides information such as identification of the issue(s) to be heard, the witnesses to be called, an estimate of the length of hearing, the legal authorities the parties intend to rely upon and any other considerations. The AG's office must also file a copy of the agency action that the petitioner is contesting.

The Scheduling Order sets out the various deadlines for the contested case hearing such as the deadline for completion of discovery and the scheduled hearing date and the place the hearing will be held. Currently, OAH is attempting to schedule the community support cases for hearing within one to two months of receipt of the petition. But this doesn't guarantee the hearing is held at that time or that the decision is entered at that time. Other cases are not scheduled this quickly.
Once the case is heard, the administrative law judge typically orders one or both of the parties to present a proposed decision. The judge reviews the proposed decision(s) and

issues a written decision in the case. The judge's decision must contain written findings of fact and conclusions of law. The law requires that the administrative law judge give "due regard to the demonstrated knowledge and expertise of the agency with respect to facts and inferences within the specialized knowledge of the agency." G.S. § 150B-34(a)

Except for those cases where the law provides that the OAH decision is the final agency decision, once the OAH decision is made, the case goes back to the agency to issue a final agency decision. OAH is responsible for compiling the official record (all of the pleadings, exhibits, and the judge's decision) in the case and delivering the official record to the Department where the case is assigned to the final agency decision maker. Delivery of the official record can take from 30 to 60 days. The law requires the final agency decision maker to review the entire record and enter a Final Agency Decision.

By law, the final agency decision maker is allowed 60 days (from the date the agency received the official record from OAH) to issue the final agency decision. Prior to issuing the decision, the final agency decision maker must notify the parties of the opportunity to "file exceptions to the decision made by the administrative law judge, and to present written arguments to those in the agency who will make the final decision or order." G.S. § 150B-36(a) After carefully reviewing the official record, together with any exceptions and written arguments, a Final Agency Decision is finally issued.

It's important to bear in mind that once a recipient appeal has been filed, if the recipient is eligible for maintenance of Medicaid services, these services shall be maintained during the pendency of the appeal. When we talk about the "pendency of the appeal" this means until the Final Agency Decision is made.

The length of time and the resources involved to obtain a Final Agency Decision under the current statutory scheme is longer and more burdensome to everyone involved than should be acceptable. The process severely impacts the recipient and falls far short of what good management of the Medicaid program demands. Federal law requires that the appeal process for recipients take no longer than 90 days from the date of filing the informal appeal to the final agency decision. 42CFR 431.244

Where a provider is concerned, the same is true. In many of the provider cases, OAH will enjoin (stay) the decision of the Medicaid program. So, for instance, in a case where the Medicaid agency has evidence a provider has violated its Medicaid provider enrollment agreement or is improperly billing the Medicaid program, or is providing poor quality service to Medicaid recipients, the Medicaid system is frequently precluded from acting against this provider during the pendency of the OAH appeal. And these appeals typically last even longer than the recipient appeals. A provider appeal can easily take more than 6 months to resolve.

Thus far, community support providers have successfully obtained temporary restraining orders and preliminary injunctions. To date, not one community support provider case at OAH involving termination, withholding or recoupment of payments has been heard on the merits. There have been two LME withdrawal of endorsement cases that have been

heard on the merits. One of the two cases, which began last summer, is still awaiting a final order from the ALJ.

Meanwhile, in a provider recoupment case, the State has already paid the federal share of the recoupment to the federal government (must do so within 60 days of the identification of the overpayment) and now the state may find itself on the hook for that payment. Additionally, as long as that provider is allowed to continue that billing practice, additional overpayments may continue to accrue during the pendency of the appeal.

III. PROPOSED APPEALS PROCESS

An alternative appeals process is provided. As many of you know, the Department currently conducts "formal appeals" for approximately 12,000 cases each year. The majority of these cases are recipients appealing county level Medicaid eligibility decisions by DSS. Pursuant to G.S. § 108A-79, the agency conducts these appeals, also know as "fair hearings". These hearings meet the federal requirements for a hearing for a Medicaid recipient. These do not go to OAH.

The proposal is that ALL Medicaid appeals be conducted by the Department – both provider and recipient appeals. The proposed legislation is very similar to the legislation in G.S. § 108A-79.

Under this proposed legislation, a recipient or provider ("petitioner") who is "aggrieved" by a decision of the Department, will have the right to appeal the decision. The petitioner will have 60 days from the date of the agency mailing of the decision being appealed, to give notice of the appeal.

Upon receipt of the notice of appeal, the Department will assign a hearing officer who will hold an evidentiary hearing as required by Federal regulations. The Department will provide the petitioner with notice of the hearing at least 15 days before the hearing by mailing a certified notice to the petitioner.

The hearing will be in front of a hearing officer – not an administrative law judge. The petitioner filing the appeal could be represented by an attorney if they wished, but it would not be necessary to have an attorney. Federal law does require that sworn testimony and cross examination be allowed to occur at this hearing. The department would usually be represented by Medicaid staff and not by an attorney except in complex cases or when petitioner has an attorney present.

It is anticipated that most hearings would be held in Wake County although the petitioner could request a telephone hearing or a hearing in the county in which the petitioner resides.

After the hearing, the hearing officer would prepare a proposal for decision and serve a copy on the petitioner and the agency. The petitioner and the agency will have 15 days from the date of the mailing of the proposal for decision to present written arguments in

opposition to or in support of the proposal for decision to the final agency decision maker who shall review such information and render a decision.

If the person appealing is dissatisfied with the decision, he would have the right to request judicial review of the decision by a Superior Court judge.

IV. NECESSARY STEPS TO IMPLEMENT PROPOSED APPEALS PROCESS

Currently, the system is a lengthy, recipient unfriendly, bureaucratic process. The proposal would simplify and streamline the process and insure a forum that is not as intimidating to a recipient as appearing at OAH where there are judges and legal pleadings.

Given the improved times this proposal will effect in processing appeals (within 90 days) and the more recipient friendly forum, the informal appeals process would be ended. The hearing officers currently involved with the informal process will now hear the formal appeals. Currently, there are five FTE hearing officers plus the chief. This number will have to be increased in order to handle these cases. Although eliminating the informal process will result in all appeals moving through the new appeals process, it is believed that given the efficiency of the proposed new process, eliminating the informal process is best.

Currently the informal hearing officers hold "in-person" hearings only in Raleigh. Under the proposal, these hearing officers would, when an in-person hearing is deemed to be appropriate, travel to the recipient's/provider's region to hear a case. Over time, as attrition thins out our current hearing officers who are all Raleigh based, we anticipate that new hearing officers hired will be residents from regions where the numbers of appeals would justify having a hearing officer in that area rather than traveling. (Currently, for the formal appeals that we do hear, there are hearing officers located in Asheville, Wilmington, Greenville and Goldsboro.)

a. Permanent Positions: The Department is still evaluating the number of positions that would need to be added if the proposal is adopted. Additional permanent positions will be needed since 1) the trend for formal appeals has been trending upwards in Medicaid, even without the community support numbers, and as our program integrity section is made more robust, we anticipate more provider cases, 2) the increase in the length of each hearing (versus the informal hearings) now that witnesses will be sworn and cross examination will occur and 3) there will be the need for travel in some cases versus all being held in Raleigh or by phone/paper. (OAH cases that are heard last from an hour to many days. Currently, the informal hearings only last one hour. Provider cases are often document intensive and will frequently last in excess of one hour.)

It is difficult to predict with certainty the exact number of positions to hear this case load, especially since it is unclear how long it will take the current backlog of community support cases to get cleared out. Preliminary estimates indicate the addition of four FTE hearing officer positions and three FTE administrative support positions will be needed.

The support positions will be responsible for intake, tracking, scheduling, and communicating with the parties, etc. (Currently there is only one permanent administrative assistant.)

b. Contract Positions: Due to the uncertainties set out above and until the community support backlog is eliminated, funding for two years for six contract positions would be needed in the event the Hearing Officer staffing above is not adequate. These positions will only be filled in the event the permanent staffing proposed is inadequate to conduct a fair hearing and issue the final agency decision within 90 days.

V. BENEFITS OF PROPOSED PROCESS

- New proposal provides a forum that will be much friendlier to recipients.
- New proposal will ensure appeals are processed more timely with a final decision within 90 days which is a federal requirement.
- New forum allows provider appeals to be heard more rapidly than at OAH where a provider case may take more than 6 months to be heard. Faster disposition of cases will prevent a provider who is providing substandard services or engaging in improper billing from continuing this activity for such an extended period of time.

MEDICAID APPEAL PROCESS

Section 1. G.S. 150B-1(e) shall be amended to add a new subsection to read:

(16) Hearings arising under the Medical Assistance program established under Part 6 of Chapter 108A and pursuant to Title XIX of the Social Security Act, shall be conducted pursuant to the provisions outlined in G.S. 108A-79 and G.S. 108A-79.1.

Section 2. G.S. 108A-79 shall be renamed to read:

108A-79. Appeals of County Level Decisions

Section 3. Chapter 108A of the General Statute is amended by adding a new section to read:

"108A-79.1 Appeals of Departmental Level Decisions

(a) The Department shall notify a Medicaid applicant or recipient of its intent to deny, terminate, suspend or reduce Medicaid eligibility or to deny, terminate, suspend or reduce Medicaid services. Such notice shall be in writing and shall contain:

(1) a statement of the agency action;
(2) the reasons for the agency action;
(3) the specific regulations or medical coverage policy that supports, or the change in law that requires, the action;
(4) an explanation of the right to a hearing, or, in cases of an action based on a change in law, the circumstances under which a hearing will be granted;
(5) the procedure by which the petitioner may obtain a hearing;
(6) notice that the petitioner may represent himself or be represented by legal counsel, a relative, a friend or other spokesman; and
(7) an explanation of the circumstances under which services are continued if a hearing is requested.

The Department shall mail the notice at least 10 days before the date of the action except when federal regulations allow immediate action to be taken.

(b) Any applicant or recipient aggrieved by a decision of the Department to deny, terminate, suspend or reduce Medicaid eligibility or to deny, terminate, suspend or reduce Medicaid services; and any provider aggrieved by a decision of the Department to reduce, deny, recoup or recover reimbursement or to deny, suspend or revoke a provider agreement shall be entitled to a hearing. A hearing shall be commenced by filing a petition with the chief hearings clerk of the Department within thirty days of the mailing of the notice by the Department of the action giving rise to the contested case. The petition shall identify the petitioner, be signed by the party or the representative of

the party and shall describe the agency action giving rise to the contested case. "File or filing" means to place the paper or item to be filed into the care and custody of the chief hearings clerk of the Department of Health and Human Services and acceptance thereof by him, except that the hearing officer may permit the papers to be filed with him in which event the hearing officer shall note thereon the filing date. The Department shall supply forms for use in these contested cases.

(c) If there is a timely request for an appeal, the Department shall promptly designate a hearing officer who shall hold an evidentiary hearing. The hearing officer shall conduct the hearing according to applicable federal law and regulations and shall ensure that:

(1) Notice of the hearing is given not less than 15 days before the hearing. The notice shall state the date, hour, and place of the hearing and shall be deemed to have been given on the date that a copy of the notice is mailed, via certified mail, to the address provided by the petitioner in the petition for hearing.

(2) The hearing shall be held in Wake County, except that the hearing officer may, after consideration of the numbers, locations and convenience of witnesses and in order to promote the ends of justice, hold the hearing by telephone or other electronic means or hold the hearing in a county in which the petitioner resides.

(3) Discovery shall be no more extensive or formal than that required by federal law and regulations applicable to such hearings. Prior to and during the hearing an applicant or recipient or his representative shall have adequate opportunity to examine his case file. No later than five days before the date of the hearing each party to a contested case shall provide to each other party a copy of any documentary evidence that the party intends to introduce at the hearing and shall identify each witness that the party intends to call.

(4) The hearing officer shall have the power to administer oaths and affirmations, subpoena the attendance of witnesses, rule on prehearing motions and regulate the conduct of the hearing.

(5) At the hearing, the parties may present such sworn evidence, law and regulations as are relevant to the issues in the case.

(6) The petitioner and the respondent agency shall have a right to be represented by a person of his choice, including an attorney obtained at his own expense.

(7) The petitioner and the respondent agency shall have the right to cross-examine witnesses as well as make a closing argument summarizing his view of the case and the law.

(8) The appeal hearing shall be recorded; however, no transcript will be prepared unless a petition for judicial review is filed pursuant to subsection (f) herein, in which case, the transcript shall be made a part of the official record. In the absence of the filing of a petition for a judicial review, the recording of the appeal hearing may be erased or otherwise destroyed 180 days after the final decision is mailed as provided in G.S. 108A-79(i)(5).

(d) The hearing officer shall decide the case based upon a preponderance of the evidence, giving deference to the demonstrated knowledge and expertise of the agency as provided by G.S. 150B- 34(a). The hearing officer shall prepare a proposal for decision, citing relevant law, regulations and evidence, which shall be served upon the petitioner or their representative by certified mail, with a copy furnished to the respondent agency.

(e) The petitioner and the respondent agency shall have 15 days from the date of the mailing of the proposal for decision to present written arguments in opposition to or in support of the proposal for decision to the designated official of the Department who is to make the final decision. If neither written arguments are presented, nor extension of time granted by the final agency decision-maker for good cause, within 15 days of the date of the mailing of the proposal for decision, the proposal for decision becomes final. If written arguments are presented, such arguments shall be considered and the final decision shall be rendered. The final decision shall be rendered not more than 90 days from the date of the filing of the petition. This time limit may be extended by agreement of the parties or by final agency decision-maker, for good cause shown, for an additional period of up to 30 days. The final decision shall be served upon the petitioner or their representative by certified mail, with a copy furnished to the respondent agency. In the absence of a petition for judicial review filed pursuant to subsection (f) herein, the final decision shall be binding upon the petitioner and the Department.

(f) Any petitioner who is dissatisfied with the final decision of the Department may file, within 30 days of the service of such decision, a petition for judicial review in the Superior Court of Wake County or of the county from which the case arose. The judicial review shall be conducted according to the provisions of Article 4, Chapter 150B, of the North Carolina General Statutes.

(g) In the event of conflict between federal law or regulations and State law or regulations, the federal law or regulations shall control.

Section 4. This Act shall be effective for all petitions that are filed on or after the effective date of this Act and for all petitions that have been previously filed at the Office of Administrative Hearings but for which a hearing on the merits has not been commenced prior to the effective date of this Act. The requirement that the agency decision must be rendered not more than 90 days from the date of the filing of the

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petition for hearing shall not apply to petitions that were filed at the Office of Administrative Hearings prior to the effective date of this Act. The Office of Administrative Hearings shall transfer all cases affected by this Act to the Department of Health and Human Services within thirty (30) days of the effective date of this Act. This Act preempts the existing informal appeal process and reconsideration review process at the Department and the existing appeal process at the Office of Administrative Hearings with regard to all appeals under the Medical Assistance Program.

THIRD QUARTER 2007-2008 UPDATE
COMMUNITY SUPPORT SERVICES
DHHS

Cos70 – Non Physician Practitioner (Medicaid)
Community Support is 80% of this expenditure category.

The checkwrites for the third quarter have been completed. Third quarter expenditures are 22% below first quarter.

FY 2007-08	
1st Quarter	**$325,110,170**
2nd Quarter	**273,605,294**
3rd Quarter	**253,867,787**

COS 070 (INCLUDES COMMUNITY SUPPORTS) EXPENDITURE DATA
OCTOBER 2005-March 27, 2008

COS 070 - Non-Physician Practitioner

	Average Expenditure of COS 070 per Checkwrite	Average % of COS 070 of Total Checkwrite	Average # of Recipients of COS 070 per Checkwrite	Average # of Units of COS 070 per Checkwrite	Average Units per Recipient for COS 070 per Checkwrite
Oct 05-March 06	2,315,186	1.2%	14,870	58,774	4
April 06-Sept 06	12,411,266	7.2%	25,673	781,197	30
Oct 06-March 07	26,123,405	12.8%	36,970	1,646,814	45
April 07-June 07	29,343,221	14.7%	43,262	2,271,128	52
July 07-Sept 07	29,551,111	14.3%	44,450	2,184,152	49
Oct 07-Dec 2007	27,357,280	13.3%	46,893	2,005,456	43
Jan 08-March 27, 2008	23,078,890	11.2%	46,551	1,624,871	35

	Requirements	State	County	Federal
Budget 07-08	972,574,943	306,020,706	42,452,896	624,101,341
Annualized 07-08	1,103,027,572	346,287,509	48,723,110	708,016,953
Difference	-130,452,629	-40,266,804	-6,270,214	-83,915,612

Community Supports was implemented in April 2006. Expenditures have been growing rapidly since. Steps have implemented to try to ensure the service was being provided appropriately, including audits of provider billing, and a reduction of the payment rate. Additionally, the amount of Community Support Services that could be provided prior to the utilization review by Value Options was reduced from 30 days to 8 qualified professional hours to develop the person centered plan, effective June 11, 2007. HB 1473, Sec. 10.49 (ee), (6) limited adults to 4 hours and children to 8 hours of service to develop the person-centered plan, additional hours require prior approval. ***SFY 08 Medicaid budget for this service is built on an average of $23.1 M per check write.***

**Community Supports was implemented in April 2006.

Checkwrite Date	Expenditures -COS 070	% of Total Checkwrite	# Recipients - COS 070	# Units - COS 070	Average Units per Recipient - COS 070	# of Checkwrite Days	Avg. Cost Per Checkwrite Day
10/10/2006	30,281,079	9.5%	39,316	1,903,452	48		
10/17/2006	16,967,723	9.8%	33,804	1,071,586	32		
10/26/2006	20,734,377	14.8%	31,384	1,317,691	42		
11/7/2006	31,400,593	9.8%	44,362	2,014,273	45		
11/14/2006	14,978,779	9.3%	26,484	933,606	35		
11/21/2006	23,949,428	13.6%	34,006	1,528,322	45		
12/5/2006	29,649,072	10.3%	41,334	1,845,394	45		
12/12/2006	20,231,025	11.0%	34,020	1,237,199	36		
12/21/2006	27,090,160	15.2%	37,409	1,748,145	47		
1/9/2007	46,577,340	11.0%	49,707	2,909,301	59	21	2,217,969
1/17/2007	20,035,466	11.6%	32,556	1,257,260	39	7	2,862,209
1/25/2007	25,239,395	15.5%	34,088	1,592,966	47	7	3,605,628
2/6/2007	40,925,350	12.4%	47,544	2,560,610	54	14	2,923,239
2/13/2007	19,464,530	11.7%	30,263	1,229,452	41	6	3,244,088
2/20/2007	28,629,157	16.9%	38,394	1,815,414	47	7	4,089,880
2/28/2007	23,500,101	15.4%	34,676	1,481,858	43	7	3,357,157
3/6/2007	23,244,492	12.1%	36,211	1,414,928	39	7	3,320,642
3/13/2007	25,008,099	13.3%	38,306	1,614,839	42	7	3,572,586
3/20/2007	26,026,945	15.2%	37,464	1,638,942	44	7	3,718,135
3/29/2007	28,534,982	18.2%	38,078	1,821,053	48	7	4,076,426
4/10/2007	44,531,366	13.0%	54,187	3,322,465	61	14	3,180,812

COS 070 (INCLUDES COMMUNITY SUPPORTS) EXPENDITURE DATA
OCTOBER 2005-March 27, 2008

Checkwrite Date	Expenditures -COS 070	% of Total Checkwrite	# Recipients - COS 070	# Units - COS 070	Average Units per Recipient - COS 070	# of Checkwrite Days	Avg. Cost Per Checkwrite Day
4/17/2007	22,413,803	13.9%	36,283	1,638,939	45	7	3,201,972
4/26/2007	28,973,251	16.7%	39,885	2,465,433	62	7	4,139,036
5/8/2007	46,077,206	13.6%	55,216	3,732,899	68	14	3,291,229
5/15/2007	25,026,409	14.1%	42,445	1,992,580	47	7	3,575,201
5/22/2007	28,471,729	16.5%	42,791	2,214,125	52	7	4,067,390
5/31/2007	25,049,781	17.6%	40,798	1,936,018	47	7	3,578,540
6/5/2007	20,846,525	15.0%	37,307	1,515,738	41	7	2,978,075
6/12/2007	24,526,438	11.6%	42,691	1,871,436	44	7	3,503,777
6/21/2007	27,515,702	14.7%	41,018	2,021,650	49	7	3,930,815
7/3/2007	45,375,417	15.5%	53,744	3,370,197	63	14	3,241,101
7/10/2007	19,823,681	12.4%	33,660	1,459,712	43	7	2,831,954
7/17/2007	23,958,513	13.7%	41,091	1,764,754	43	7	3,422,645
7/26/2007	26,798,380	16.4%	42,478	1,996,498	47	7	3,828,340
8/7/2007	42,261,348	13.1%	52,438	3,143,855	60	14	3,018,668
8/14/2007	24,120,447	14.0%	40,869	1,831,157	45	7	3,445,778
8/21/2007	27,890,256	16.1%	44,604	2,078,330	47	7	3,984,322
9/5/2007	40,602,475	14.2%	53,847	2,979,918	55	14	2,900,177
9/11/2007	20,894,525	12.1%	38,097	1,540,173	40	7	2,984,932
9/18/2007	26,388,800	13.7%	43,822	1,862,371	42	7	3,769,829
9/27/2007	26,948,385	16.1%	44,300	1,998,705	45	7	3,849,769
10/9/2007	44,426,008	12.8%	57,420	3,255,099	57	14	3,173,286
10/16/2007	23,792,053	12.9%	43,418	1,686,174	39	7	3,398,865
10/23/2007	24,945,870	15.2%	44,535	1,845,094	41	7	3,563,696
10/31/2007	22,604,836	15.7%	42,490	1,638,816	39	7	3,229,262
11/6/2007	22,423,534	12.3%	42,736	1,646,976	39	7	3,203,362
11/14/2007	23,224,279	11.8%	44,412	1,641,352	37	7	3,317,754
11/21/2007	27,443,975	15.6%	48,121	1,989,330	41	7	3,920,568
12/4/2007	37,115,152	13.2%	54,438	2,693,034	49	14	2,651,082
12/11/2007	19,981,728	10.5%	42,166	1,687,217	40	7	2,854,533
12/20/2007	27,615,361	12.7%	49,194	1,971,469	40	7	3,945,052
1/8/2008	37,606,234	9.1%	55,371	2,773,267	50	21	1,790,773
1/15/2008	20,956,853	10.9%	40,915	1,429,190	35	7	2,993,836
1/24/2008	21,621,018	14.1%	44,392	1,557,408	35	7	3,088,717
2/5/2008	34,881,071	11.3%	57,321	2,493,730	44	14	2,491,505
2/12/2008	18,433,035	8.6%	43,160	1,245,445	29	7	2,633,291
2/19/2008	21,937,659	11.8%	46,446	1,505,955	32	7	3,133,951
2/28/2008	19,548,168	12.8%	43,600	1,406,558	32	7	2,792,595
3/4/2008	19,110,676	11.3%	44,031	1,339,823	30	7	2,730,097
3/11/2008	18,690,623	10.2%	43,256	1,261,445	29	7	2,670,089
3/18/2008	21,104,159	10.7%	48,285	1,435,788	30	7	3,014,880
3/27/2008	19,978,291	12.4%	45,289	1,424,976	31	7	2,854,042